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ABSTRACT

Based on the family systems approach to therapeutic intervention, the first part of this paper develops themes of adolescent development in family contexts. Specific attention is given to adolescents' relationships with their parents, their role in the family, the way in which they develop within this role, and the ways such development affects them in relation to society as a whole. In subsequent discussion, emphasis shifts to situations resulting in unusual, irregular adolescent development. Particular attention is given to adolescents who have difficulty in separating from their families, who separate in destructive ways, or who develop deviant social roles. Overall, themes are developed as they relate to atypical families. The terminology of "normal" and "abnormal" is avoided on the grounds that it implies an invalid way of looking at adolescent development and the various themes that emerge in this process. In addition, personal identity is viewed as exhibiting both individual characteristics and the social function of control. Processes of "delegation" and "binding" of adolescents in family contexts are described and illustrated. In conclusion, common causes of adolescent depression and the nature and concomitants of the defense mechanism of "acting out" are delineated. (RH)

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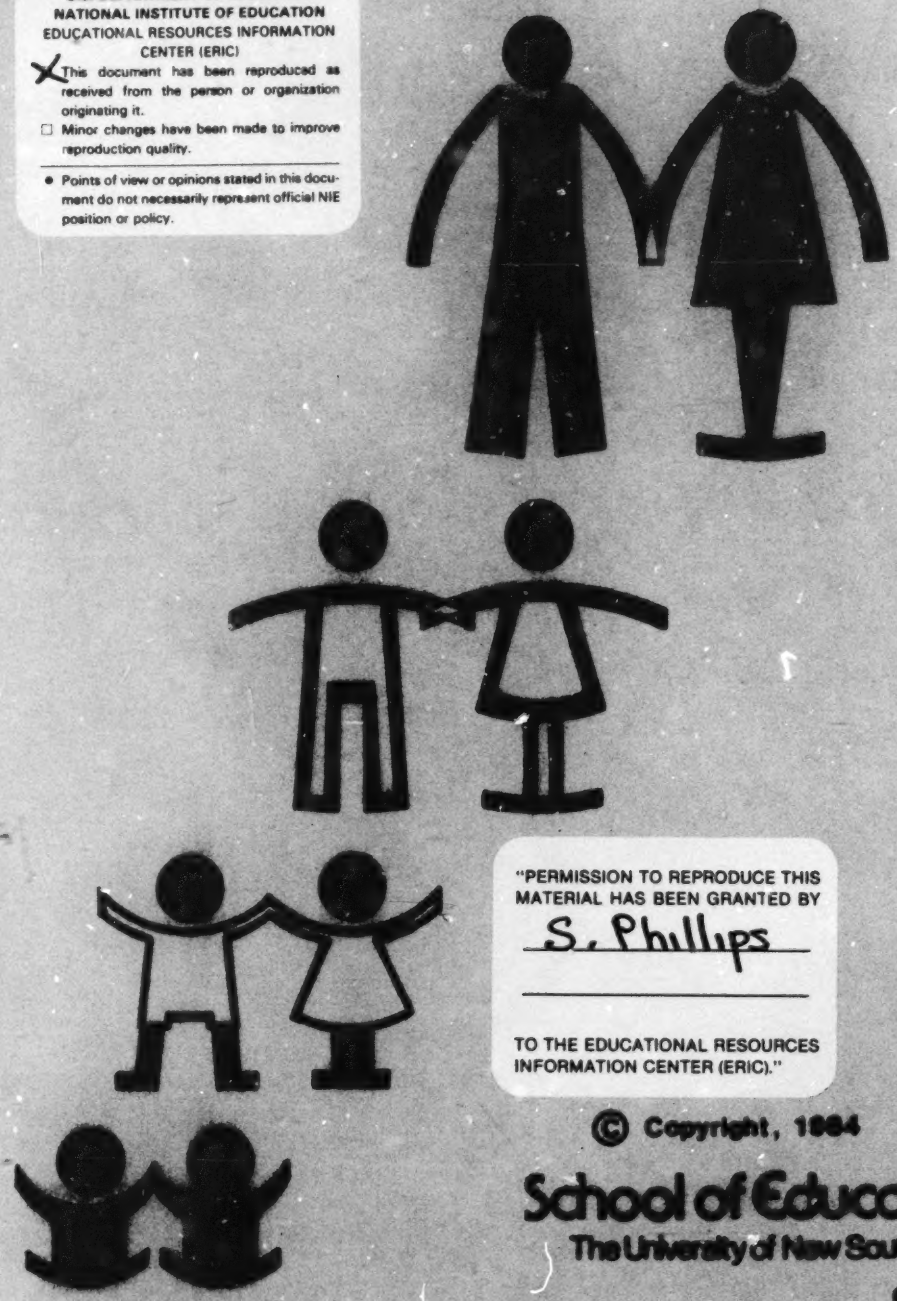

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ADOLESCENT'S SEPARATION FROM THEIR FAMILIES

by

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ADOLESCENT'S SEPARATION FROM THEIR FAMILIES

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INTRODUCTION

The first part of this paper will develop some themes of adolescent development as it pertains to the family. It will concentrate on the adolescents' relationship with their parents, their role in the family, the way in which they develop within this role, and how that affects them in relation to the outer society.

In the latter part of the paper the emphasis will shift to some situations which lead to aspects of abnormal adolescent development, and focus particularly on adolescents who have difficulty in separating from their families, or who separate in destructive ways, or who develop deviant social roles. Overall, I want to be able to develop themes of different or atypical families, yet not completely separate the usual and the unusual. I do not particularly like the word "normal". "Usual" or "ordinary" seem better descriptions because normality rests on cultural prescriptions. The terms "normal" and "abnormal" give a medical notion of health and disease, and, while I am a doctor, I think it is a very invalid way of looking at adolescent development and the various themes that emerge in this process.

The Family as a System

First, I shall talk about adolescents in terms of "the family system". In child psychiatry we approach families as a whole and look at the particular roles a child plays in the family. In assessing families we look at a great number of issues, and not only the core of the family - the nuclear family - but also the extended family of uncles, aunts and grandparents, and also the role the family dog or cat may play. We look at the total family, and further look at it as a social unit that has a life of its own, and hence, we talk about "the family system", i.e. the appropriate system to be studying in its own right.

When a child with a problem is brought along to my team, we first ask what this means in terms of the family. For example, a 12 year old girl was brought to us; the family said they were very concerned because she was irritable, angry, and broke down and cried often. Even though the daughter was being presented as the patient, we found in looking at the family that, although concerned about her daughter, the mother exhibited many sad, unmet needs as well as depressive and morbid preoccupation. Father was not in touch with his feelings. He was isolated from them and expressed this by being very logical; he was also an extremely verbal and powerful man. The younger child was very conformist and checked the parents' faces before he ventured anything; a cautious and timid boy approximately three years younger than his sister. It soon became clear that when anything happened that the girl did not like she instantly rebutted it with remarks such as: "I don't like that", "That's a put down." If she was upset, she might cry.

We formed the impression that this girl had a lot of strong feelings and was in touch with them. In our view of families we look for such qualities as a resource, and yet this family regarded the girls' behaviour as abnormal. They did not accept it: "We don't like it when she is angry, when she is frustrated or does not like what we say to her. She is becoming too strong." The mother, as indicated, was depressed, the younger child was

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timid, and father was detached from his feeling self. It soon became apparent that mother and father had a coalition of power in the family, and they also held the leadership which was threatened because the girl was, in part, taking over.

Now, of course, we do not, as therapists, indicate that the mother is the "patient"; instead we see the family as having difficulty in functioning. The members were clearly hurting in various ways, and had difficulty in adapting to things that change or cause strong feelings. They were troubled by the inevitable transactional phase at the beginning of this girl's adolescence, and were finding it particularly difficult to cope with her development. Although puberty is not usually a big crisis in adolescence, compared with the death of a parent, leaving home, or divorce, for example, this family was still not able to cope.

Our response in such situations is to indicate that the whole family needs help and are asking for help. As therapists we do not immediately collude with the parents and say the girl is the patient, and listen to them as they tell of their problems with their daughter. We do not indicate that we must solve the problem for them. That approach would be very simplistic. We recognise the mother's pain, and that she might not be conscious of it or able to give it verbal expression; and we show we are aware that the father has had to adapt to pain early in his life by isolating his feelings, and that is why he has become a talking, thinking, logical machine. We also show we are aware that this sense of crisis is shared by the whole family system, and that it is not an individual matter. It is a family going through the crisis of having a child enter adolescence, and it is the family as a whole that is involved.

If we were not to take this family point of view and, instead, take a medical or moral model, we would think and act differently. If, for example, we took a moral model which says that the child is "bad" and what she is doing is wrong, antisocial and sinful, we would come up with different ideas. If we took a legal model we would be concerned with potential law breaking, and so on. Thus, the model influences how one approaches a situation. The medical model would lead to a perspective which was centred on sickness and disease, diagnosis and treatment; whereas the model we are using in looking at the family is essentially a "social system model". It involves seeing the family as a unit and assessing why they are not functioning adequately in this particular crisis.

Special Roles

There are many situations that may be usefully interpreted using the family systems model. For example, it may be that the adolescent has the *special role* of the "sick one" in the family. It may be a serious disease such as diabetes or cystic fibrosis. The medical students at Newcastle University are each attached to a family which has one member with a chronic illness, to see how that family, as a system, copes and adapts, and what kinds of mechanisms and defences they develop to handle the situation. In tutorials the students report how the family is coping and that enables them to get a broader view of how different family systems operate in such situations.

At the Adolescent Medical Unit at the Royal Alexandra Hospital for Children, we see many adolescents who have been given the "sick" role, and are brought in by the family. They usually present with abdominal pains, headaches, joint pain or other symptoms. Many of these children have been to many specialists and had many x-rays and tests, with little or no results, and they go

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from specialist to specialist before they come to the physicians in the Adolescent Medical Unit. The illness behaviour of many of these children has a family system cause. They are usually very close to one parent, and are involved in what we call a "vertical marriage". Such mother and child "marriages" may develop into a stable relationship over many years and are often a way of coping with, or adapting to, marital interactions which are unsatisfactory. For example, the mother may not have the quality of closeness she had hoped for with her husband and, instead, develops a close emotional relationship with one of her children. This is not an incestuous relationship, but one that indicates they are the most important person to each other. They are emotionally invested in each other, very close and very sensitive to each other's needs and feelings, and many of their intimate, high-quality interpersonal needs are met by one another. Often, they form a special twosome in the family.

Sometimes, where parents form a vertical relationship of this nature with children, you have one parent forming a special relationship with one child, and the other parent becoming close to another child, and perhaps one is left out if there are three children in that family. This is what we call the "five person family syndrome" and it is the one who is left out who often presents as the patient, as they are usually distressed at being left out. There are other variations, but that is one of the most simple examples.

Where there is such a close relationship, and the child becomes ill, the worries in the family could be about many things. It may be that the father has some serious organic illness and denies it; it may be that the mother is depressed, or the marriage is unstable; it may be that the family is very needy of high-quality relationships, or needs continual reassurance about the health of the adolescent member of the close twosome. There are many possible dynamic reasons which may lead to a particular child becoming the one that develops the illness and the pain, the headaches and the undiagnosable symptoms. Sometimes, there is a hostile reaction against doctors (and if you look back into the family history, you will hear, for example, that "Dr Smith did not diagnose grandma's cancer until it was 'too late'."), which makes it a complicated and distressing situation.

But, usually the adolescent's illness serves a family need in that the family needs a distraction from their problems. When the problem is with the marriage, it may be that when the child is sick, the parents work together and are mutually worried and this helps bring the family together. Sometimes, if the mother is depressed, she can externalise all her tension by focusing on the sick child. This keeps the mother going, and, as she is the pivotal person in the family, this also keeps the family functioning. So the child is allotted the "sick role", the "special" role, for the family. The common roles are the "sick" one, the "mad" one, and the "bad" one. There are, however, many other "special" roles. Teachers, for example, know the "clown" as a special role in the class.

The Powerful Influence of the Family on the Adolescent

We are essentially talking about group behaviour, and here, I am discussing a very special group - the family. The family is different from most groups in that the people are so familiar with one another that they have established ground rules and stable ways of interacting. They play special psychological games with one another, and there is a stability in family group dynamics, contrasting with the fluctuations you get in group therapy or seminars, for example.

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This is relevant to the adolescent who is part of a family. In early adolescence, adolescents are "locked" into the family, and even later in adolescence the adolescent is spiritually, dynamically, socially, part of the family. Even the adolescent who has run away and is drifting on the edges of groups, in places like Kings Cross, and is introduced to prostitution and drugs, is still part of the family, even though the family may have cast him/her out, or he/she may have left because it gave him/her no role, validation, or self-esteem during his/her development. He/she is still a reflection of that family. Even the psychiatric patient in the admission centre, who lives on his/her own and comes into the psychiatric hospital when things are not going well, is still a product of the family from which he/she came. He/she is often where he/she is because of the lack of an assigned role, self-esteem, or validation in the family that lead to the present isolation, or early damage to personality.

Crisis and Vulnerability in Adolescence

The important thing about adolescence is that it comes after childhood. One must remember that the child development that comes before, is the platform from which the child moves into adolescence. Some of the disturbed adolescents are those that come from an earlier disruptive family situation, and who have already been allocated "special" roles. They have disturbed development in the form of separations, traumas and destructive relationships with parents, and it is these children who, when they come into the crisis of adolescence, are particularly vulnerable.

Many of the children who need individual therapy in adolescence, have had a disturbed childhood and there is a great deal of damage to be undone. When I talk about a crisis in adolescence, I mean an event or change that is perceived by the person or the family as causing upset or difficulty and needing new adaptive measures. I am not talking about a simple change of direction. Crises can be of many degrees, and they can be slight, or heightened to a degree that they lead to family disruption or breakdown, and the development of maladaptive special roles.

One may ask why entering adolescence can cause a crisis? Part of the answer is the reaction of parents to the adolescent, and part of it is cultural. In our culture, adolescence is prolonged beyond pubertal changes. Many issues are important. For example, there is a redirection of many feelings and motivations and, perhaps, recurrence of early behaviour such as aggression. They have to become used to different feelings in parts of their bodies. There are sexual changes, and adolescents need to become used to a different shaped body, with different distribution of fat and hair, for example. Their self-image very much affects their self-esteem, and this may or may not be supported by other members of the family. For example, one girl of 12½ years with anorexia nervosa remarked she did not like her "bottom" because "there is too much of it", and she was greatly upset because her young brother would call her "Fatso" and tease her, and her parents did not try to stop him. She became very preoccupied with all the teasing and its content in an obsessional way. It was a difficult issue for her and part of the beginning of her anorexia nervosa.

Parents are often frightened by their adolescents' emerging sexuality, and sometimes their aggression, particularly if the child is larger and stronger. Mostly, the problem is the parents' projection of their own ideas or experience: as in the case of a father who little understands his adolescent daughter because it involves issues with which he is not familiar. He is unable to change his way of thinking, and think anew of the different world and

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time in which his daughter lives. Over recent decades things have changed so rapidly that adolescent culture is vastly different from that experienced by those even ten years older. This also often applies to teachers. Teachers are often out-of-touch with contemporary adolescents, and the school counsellor is often so down-graded by the education system, he/she cannot help sufficiently.

One needs to ask what is different about the adolescent's needs of today and those of yesterday. To say to an adolescent "I know how you feel" may not necessarily be accepted as readily as will body and facial responses appropriate to genuine sympathy. Adolescents are tuned to these responses and this gives them the feeling that you understand. Mostly, they want parents to indicate in this manner their understanding of what they are going through. They need the parent as a safe, responsive listener to whom they can return after they have been out in the world and have explored other relationships and achievements.

Changing Mental Capacities

You will have heard of Jean Piaget who studied children's understanding and thought in great detail, and how they draw conclusions, and this is discussed in the Foundation for Child Studies' Selected Paper No. 30. Piaget (1969) noted that at about 8½ years children start to think logically and without the magical ideas they often have at younger ages. At 12-13 years many develop in such a way that they can use abstract symbols and can hypothesise and deal in ideas and manipulate them. These are the same resources an adult has. The 13-14 year old has the mental capacities of an adult. This is a big and subtle change for a child and one to which our culture gives little recognition or support. Despite the fact that 4 year olds and 8 year olds and 13 year olds may all be at different stages in their level of reasoning, many parents with children of these ages, or those with 15, 11, and 7 year olds, believe in the notion of "treating all children the same", and yet, all are different in their ability to carry out complex instructions. A 7 year old still needs parents as an auxiliary to their thinking, to work out what is appropriate and sensible and, for all their precociousness, 7 year olds need parents as advisors. A 15 year old, unless there is divergent development, has the mental apparatus to think things out independently, but does not have the experience, and often needs the parents to contain his/her impulses, and to act as a back-up. Nevertheless, 15 year olds need to try out things for themselves and they learn rapidly. Unfortunately, children with a "special role" may find it more difficult.

The maturation of thought and its application to experience is the primary task of adolescence. These are not only intertwined with the adolescent's ordinary emotional development, but also their relationships. For example, an adolescent male may need to separate from his father whom he previously hero worshipped. Some fathers do not recognise the adolescent's need to develop their own relationships and interests, and may miss the opportunity for later good friendship by being difficult about independence in adolescence. Where there has been a good relationship, many co-operative ventures will continue, but probably at a diminished level. Adolescents are very interested in their independence and are taking note of other adults. They reality-test their parents and compare them with other adults and note differences in what parents say and do. They can be very judgemental with their new-found perspective on right and wrong. Parents begin to come down off their pedastals for them as they test out their values and their consistencies.

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Adolescents tend to treat home as a security base, rather like an aircraft carrier from which they make sorties out into the world to try new relationships and then return home for nurturing, good listening, and even seven-year-old-type comfort if things have been very rough for them in their early trying of their wings. Many parents become very angry at this "departure" and "return-for-comfort" process. They do not accept that this need for a secure base from which to gain strength for new testing in the outside world is an important part of the adolescent's emerging independence. The adolescent needs to know that his/her parents are not going to walk out on their talk, be shocked, or put them down. One does not need to solve his/her problems. Listening is sufficient. One, as a parent, needs to explore one's own feelings so that non-validating messages are not transmitted by body language. It is important not to be "phony" - insincere. When irritated by an adolescent it is important to say so, yet remain interested.

The Shape of the Family

The shape of an adolescent's family and the role and relationships he/she has been given by the family, influence greatly what happens to him/her. For example, whether or not the adolescent is the eldest, influences the situation. Parents tend to "experiment" with the eldest because usually, they have not had responsibility for an adolescent before. Some of this experimentation can backfire because children in families can be very different temperamentally, physically, or in natural ability. Many parents find these differences distressing and unacceptable. Consider an adolescent whose brothers have collected trophies of all kinds for their sporting endeavours, and the house is decorated with them, but, this boy, on the other hand, is very short-sighted and cannot catch a ball. The parents are not able to validate the things he can do and the decoration of the house with the brothers' trophies is a continual reminder of what he cannot do. He is different. Parents often have difficulty in coping flexibly with the differences in their children who are each doing things in their own way. They may also have difficulty in coping with each child's successive adolescence, because it is different from the previous child's adolescence. However, it is most difficult for the older child, sometimes because the parents have to come to terms with their own adolescence through him/her.

There may be extra stress in families during the time children are entering adolescence. It is also a time when parents may separate and the adolescent becomes a member of a single parent family. The family break-up or loss can be very stressful. Or perhaps the adolescent has been in a single parent family after a loss, and the family is now becoming a blended family. Many adolescents may have two parents, but their parents' marriage is a dysfunctional marriage where there is the threat of break-up and continual fighting. There are also adolescents with multi-generational families where the grandparents live with them, or there are families where one of the older children has the role of "parent".

Thus, in looking at any child, one always needs to look at the type of family the child comes from and where he/she fits into that family. The family structure will affect the adolescent profoundly.

Early Childhood is the Foundation of Adolescence

As mentioned earlier, the adolescent is a product of his/her earlier childhood. Erik Erikson (1968), who has greatly influenced therapists, argues from clinical research that the early development of trust in the infant is very

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important for later life, as are the tasks of consequent stages such as developing autonomy, initiative and a sense of competence.

In adolescence, the task of autonomy is very important. It begins to emerge strongly at 2 years of age, when the child is first testing his/her skills and limits. It is important that the child is not crushed at this early stage as this influences how he/she behaves later in adolescence when trying out new areas of autonomy and separation from the parent.

If the young child has begun to develop a good sense of his/her own autonomy, then he/she can begin to tackle the next task, which is that of generating self-initiative and at the same time containing feelings of guilt and uncertainty for doing so. The child needs to learn to be confident. The learning of this task is uppermost at the time when the child starts school and, if he/she has been able to develop sufficient sense of autonomy and initiative, the next major task involves developing a personal feeling of adequacy. Can he/she achieve things? The acquiring of autonomy, initiative and adequacy depends upon receiving plenty of feedback, praise and validation from parents. There is, in every child, the show-off aspect which involves being good at something and having a relationship with someone, usually a parent, who validates them and accepts them for themselves. If a child has to achieve in order to be accepted by his/her own parents, he/she is in a difficult situation. If he/she is accepted as a person in his/her own right, then a sense of adequacy will follow, and this becomes the core of identity.

Identity, or the development of "who I am" is crucial to adolescents. It is based on their capacities and the influences of the kind of family he or she comes from. Identity is also one way in which society controls people, because it involves the seeking and keeping of jobs, and living a lifestyle that maintains conformity and hence, social stability. Identity is not only a personal sense of achievement, but a means of social control. Humans are very much social beings and need a social place, one that is secure, all of which is involved in identity development.

Erikson goes on to delineate other stages of development, namely those of intimacy, and wanting to generate children, and a sense of self-integrity in later life, but these are beyond the scope of what we are discussing here. Erikson's theory can be useful for those who are confused by the intricacies of writers such as Klein and Freud.

As the child enters adolescence, the issues of industry, competence, initiative and getting parental feedback and validation is central to the following pursuit of identity. Adolescents who are disenchanted by failure, the prospect of unemployment, or a disturbed family, have more difficulty in attaining a sense of identity. Schools can be very important at this stage if a family is failing. Many such adolescents gain direction from a leader in a group, or from a school teacher, an older boy, or their peer group. An adolescent whose family does not respect him/her and has not a lot to give, or does not have a role for him/her, has a very difficult time in making this up with other people, especially as his/her family matters a great deal. It is often not sufficient that an outsider gives him/her validation, praise or encouragement when he/she is disparaged or given a bad or hopeless role at home. Those who have read *Catcher in the Rye* (Salinger, 1969) will see Holden Caulfield experiencing many difficulties in discovering his identity - knowing who he is. He drifts, follows one direction which does not lead anywhere, and cannot make sense of it. It is families like his where the family development already has problems that makes special difficulties for the adolescents.

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Some are confused because a parent has failed, and either wants his/her children to fail and not exceed him/her, or wants the child to make up for everything the parent did not do as an adolescent. The parent may be determined to gain a second chance at life by reliving it through the child. These two extremes are very destructive to an adolescent. One of the problems for an adolescent, is that the parents are more powerful and whatever "hang-ups" they received from an earlier generation are now likely to pose further problems for the adolescent.

The Adolescent and Schools

We also have a disadvantage with our large secondary schools. Children who are atypical can be overlooked. In any one very large secondary school there are at least 100 disturbed adolescents, and often, the school counsellor has many other schools to service. Private schools also have their numbers of disturbed children. Another difficulty schools have, is that children tend to function as groups or cliques in the class or playground and if there is a dysfunctional situation in which a teacher cannot interact with adolescents, cannot communicate congruently, or is often not there, the result can be children who are angry or hurt and react as a group. Someone is pushed into the fight-leadership role, and children who are cast in this special role, as in families, are often children who are more disturbed and need the attention and notoriety. They are the children who often give the teacher "cheek" and do things to attract attention. Schools need to understand these group dynamics and sometimes the family role of the children in their care can be helpful, too. Sometimes in the leadership role there is the child whose parents are extremely over disciplining and controlling, and the child is afraid to step out of place at home. When he/she gets to school, teachers are "softies" by comparison. He/she often identifies with the father and imitates father's behaviours and tries them out at school. The parents are amazed to hear their child is badly behaved at school and point out that they have no trouble at home. Their reaction: "What's wrong with this school." The school is bewildered.

Consider an adolescent from a middle class family with a warm, stable mother who meets her three children's needs, yet one adolescent is not doing well at school even though his IQ is very high. Sometimes he writes good essays and is good at art, but otherwise, his performance is mediocre; he is rude to teachers, is playing up and being generally objectionable and not getting on well with his peers. His development and his relationship with his mother is good. However, after some sessions with the family, it became apparent that father had a chip on his shoulder about his own schooldays, and was still angry and resentful at teachers whom he saw as having done unforgiveable things to him, and he passed on to his son a very negative view of schooling and teachers. The son has identified with the father, and, in any other family, this would have been very healthy. What was happening in this particular case, was that the son was "acting out" his father's hostility to school systems. This was an intuitive act on both their parts and was not something the father had consciously planned or thought out. Very tactfully and gently we helped the father through his hostilities and the situation eased. When last we heard, the boy was performing up to the level that might be expected of his IQ and his behaviour was acceptable at school.

Other syndromes one sees at school are timid boys who are bullied, are then emotionally incontinent, and overreact, crying and pleading. Some children are sadistic because they have grown up in a sadistic home and will emulate this behaviour, taking advantage of the timid ones.

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There is very rarely trouble from schools due to dysfunctional teachers because of the way our system is set up. Rarely is there a situation where you have a disturbed teacher and where the Head, or the person in charge, is not functioning well enough to contain the problem. As the system operates, there is someone in charge next up in the hierarchy who gives the problematic teacher feedback and does not allow excesses. But occasionally school systems do not function well: For example, consider the case of a teacher who was a perfectionist and led a very restricted home life looking after an elderly parent. The principal, a nun, was supportive and the system worked well for years, and classes did well until the principal was moved and the incoming principal was unaware that the teacher had any problems. Without the support she had previously received the teacher began to concentrate upon, and pressurise the able children and neglect and reject the others, and so was able to act out her problems unchecked. As a result, a number of children from her class presented with major behavioural problems.

The Adolescent and School Refusal

Finally, in this section of the paper, I shall say something about another problem that can involve the adolescent, and that is school refusal. I should point out, that there is a major difference between truancy and school refusal in adolescence. Truancy usually occurs in a group associated with minor antisocial behaviour and petty theft. In the peer group it is a status issue. It is often related to school factors.

School refusal on the other hand, is a condition where the child stays at home, ostensibly ill. The home situation is pivotal and the child is anxious about what might happen at home if he/she leaves for school because he/she is receiving messages that a parent needs him/her, or that a parent might leave or become depressed. Often there have been multiple losses in the family, and the child is anxious that someone might die or leave. The parent is often colluding in giving anxious messages that they can stay home, while overtly appearing to press the child to go to school. Sometimes the parent is not colluding - and yet the child is anxious about home.

So it is important to distinguish between truancy and school refusal. In truancy situations the family is more often blamed, and in school refusal situations the school is more often blamed, and this reversal is usually because all factors are not examined carefully.

Delegating and Binding the Adolescent

I shall now discuss the ideas of Helm Stierlin (1973) on issues relating to adolescent development leading up to the departure of the adolescent from the family. How do families manage their transition? Do they manage it easily or with difficulty? Is the adolescent having particular difficulty in breaking from one parent?

In general practice, I once saw a man aged 72 who told me his mother had sent him. He was still locked into the relationship with his mother. At other times the relationship can be extrusive, as in a case where the child is a product of the first marriage, is nine years old, female, and spends her time wandering the back streets of her town, leaving the house whenever she can, and is highly vulnerable. This family consists of mother, stepfather, and other children, and they do not want her and are actively excluding her. So one can see all extremes.

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Stierlin puts forward the idea that an adolescent in this stage of his/her development and the process of separation from his/her family develops a role given to him/her by the family. He/she is both sent out, and has a mission, so that the family provides his or her role in leaving the family. This is one way an adolescent develops apart from the family system but still keeps a role from that system. Stierlin points out that some of these delegated roles may be very healthy and creative, and fit in with the adolescent's own ideas of what they want to be. On the other hand, they may be most unrealistic and conflict strongly with what the adolescent wants to do with his/her own life. For example, a parent delegates the adolescent to be a musician or a great tennis player, and the adolescent's real ability and desires are very different. We see examples of this when interviewing would-be medical students for entrance to University. From some students one receives the clear message that they are there because their parents have delegated them to become a doctor. They may want to be a marine biologist or a pilot. There is a conflict which may not be superficially obvious.

More subtle conflicts appear in adolescents who have one delegation from mother, another from father, and possibly one from grandfather. Some are delegated into different roles by the same parent. Thus, at one level, he/she is delegated into an adventurous role trying out illegal things on behalf of the parent (cued by the parent's excitement and interest), and at another level he/she is meant to succeed in a profession. Thus, one must look at the underlying delegation and how this conflicts or fits in with the adolescent's own life plan or script. Unfortunately for the adolescent, the parents' delegation may be very subtle and come through at an emotional level, or as a suggestion, and not explicitly. Psychosis can be delegated but it comes out as pseudo-psychosis. It is to be distinguished from biological psychosis. In pseudo-psychosis the patient takes on a role that is determined by the family, including the details of "mad" behaviour. In such cases one can see sudden "cures". It is also to be distinguished from psychoses which are due to pathological parenting and severe attachment problems. Such children will not wholly recover; the psychosis has become part of their personality and is distinct from pseudo-psychosis (Rickarby, 1984a).

Stierlin believes parental delegation of an adolescent can be healthy if it is realistic, and unhealthy if not. For example, if the parents want a child who is afraid to ride on a merry-go-round to be a pilot, or their son with very low academic ability to be a teacher, there is conflict between reality and the delegation.

The delegation/development issue is in contrast to the issue of binding. Adolescents can be bound into families in various ways. For example, their needs may be met excessively. One example is the adolescent whose bed is made, and shirts and socks are laid out for him on all occasions before he dresses. His favourite dishes are constantly prepared and he has had little opportunity to fend for himself. Every gratification of his every biological need is a strong factor binding him to the family or to the particular parent.

Another way in which binding can occur is by creating confusion as to what kind of person the child and adolescent is. Their own model of themselves, or their scheme of who and what they are, can be very confused by binding parents. They can give the child mixed messages, particularly of the low self-esteem type, such as "You are no good at that!" "You will never get a job in the field you want." "People always think such and such of you." "You always do that when you come to such and such a point in a relationship." and so on. There is a confusion about the cognitive things that they know about themselves. These are the issues that Laing and Esterton (1964) and Haley and Hoffman (1968) and others who write about families talk about, namely the confusing word games parents play.

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Another common problem in binding processes, is the adolescent who is bound to their parent/s by guilt and a sense that they have a massive duty to them. From the beginning, their separation anxiety was provoked by the parent when they were "naughty". Perhaps the parent threatened to send them away, or to leave themself. Guilt was attached to separation anxiety.

People vary enormously in their capacity for guilt. At one end of the scale there is the so-called psychopath who can kill and not feel the faintest qualm of guilt. At the other end of the scale are people for whom guilt is so overwhelming and terrifying that they live their whole life to prevent it. They have to go around acting toward other people in such a way to prevent the slightest possible guilt occurring in themselves. They also have to use the mechanism whereby, if there is any sense of badness or feeling approaching guilt, they see badness in other people. One of their ways of coping is to surround themselves with a few obvious "baddies" - scapegoats who are so obviously bad that it is easy to see badness outside of themelves. These are the two extremes of the manner in which people handle guilt. In between these extremes are people who use projective mechanisms and "baddies" to prevent guilt feelings in themselves but who can bear a little guilt and know they feel guilty. Then there are those who can bear guilt sufficiently to think about what caused it and not do it again. There are also those who are not happy about their own behaviour, and they can interpret it, but they can cope with guilt feelings and will adjust their lives accordingly. Then there are those who experience but little guilt and believes that expediency overrides all. So there is a spectrum of the ways in which people handle guilt. Guilt is a socially conditioned anxiety. Guilt is not a primary anxiety in the way fear can be.

So what we are discussing here is someone who is bound into their family by guilt, and they have been trained so that if they have a thought of which their parent/s would disapprove, it is very painful for them. They cannot bear it and believe their parents must be right. To think badly about their parents or their parents' motives is painful. When someone like this enters into psychotherapy, and it becomes obvious after, say session five, that they are being controlled (like a pawn on a chess board) by the parent, and they are unable to gain insight into this or that, or show anger, then it is clear that their own development has been arrested because of it. If you explain to them that most people would tell their parent/s "to jump in the lake" in such a situation, this particular person would leave the treatment and not return, because, to them, it is an untenable way to think. So, one has to take them very gently through their development vis á vis their relationship with their parents. It is easier to do this via their present relationship with the therapist. For example, if *you* are late for an appointment, they will make all manner of excuses for you, perhaps saying they were too early, etc., and will brush over your apology. From this reluctance to express their rights in relation to you, one can often work through to their relationship with their parent/s.

In assessing an adolescent it is important to see if he or she is bound to the parents and what mechanisms are protecting the situation. One also asks what was done to the parents themselves, because often they are repeating their own experiences with *their* parents, and what was done to them. Sometimes it is the parents' own separation anxiety that is at the basis of their own binding behaviour toward their child. They want to make sure that someone is always with them.

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One of the extreme examples one sees is where the adolescent daughter is given all manner of messages as to how wonderful babies are. Mother has had five and there has been a baby around for most of her adult life. However, one cannot keep on having babies, so the 15 or 16 year old daughter receives a covert message. Although she is told *not* to become involved with a boy (and with all the details supplied), somehow she becomes pregnant and her mother has another baby. The adolescent is then excluded by maternal power and her mother has another attachment figure in the baby to bind to her over a long period. This is another aspect of binding.

Other types of delegation are less obvious, but more potent. The parent who has lived a very humdrum adolescence and missed out on a lot of aggressive and sexual development is such a one. They have missed trying out a variety of relationships and somehow, their own adolescent child seems to do all the things the parent missed, to the nth degree. The adolescent receives the message that the sexuality, drug usage, etc. is bad, but the parent shows a great deal of excitement in hearing about it and being shocked, and experiencing it vicariously. This gives the adolescent considerable reward; yet they are both bound by it. Sometimes, it is part of the parent's curiosity about the world. The housebound parent will encourage the daughter to take herself and her rucksack through East and West Germany, Katmandu, and so on, and to come back to the family to supply the experiences the parent has missed.

Similar types of delegation may be the parent who wants a second chance at life and becomes very close to the adolescent and what he/she is doing. They are particularly involved in the child's successes and failures. It is their own chance to relive vicariously that part of their life which they feel they missed, or where they missed self-esteem, lost or did not find gratification or mastery. It may be the adolescent's delegated role is to turn out badly and so demonstrate that their other parent is destructive and had a bad influence.

Another instance is the parent who delegates the adolescent to repeat a role from their own family of origin. For example, the adolescent who is assigned the role of their Uncle Jack who, in his adolescence, made a lot of trouble for his parents. The present mother was the sister of Jack. She yearns to give the child Jack's role in order to come to grips with what occurred in her own past, and to be in the powerful parental position and not in the helpless position of the little sister. It may be that in the repetition such a person gains revenge or control and so "masters" a problem the second time around. The child's training to such a delegated role may involve conflicting messages such as "you must not do this" but with all manner of details supplied. You hear such a parent saying "I am frightened he will go out and steal something from Woolworths", and, sure enough, the child goes to Woolworths and steals.

Often where you have one parent in the family who is particularly authoritarian, the children recreate the role when they become parents. This process surrounds such a parent with familiar role figures, but also offers these aspects of repetition which means they have more control and are not as helpless as they once were. It can also be a justification for what the parent's own parents did, and a protection against their being extremely angry at them.

Fortunately for adolescents they do many things on their own initiative, but also, because they are so reliant upon leadership and locked into dyadic relationships with their parents, they accept these delegated roles.

For assessment one needs to look at both the family as a whole and the roles within it, particularly the adolescent's relationship with the power figure in the family. Sometimes parents do not delegate their adolescent's to *any* role. The adolescent then has nothing but dead ends. They lack self-esteem and val-

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idation of their development.

Delegation can be considered as a "normal" or "distinctive" process, whereas the notion of binding, is somewhat more consistently pathological and usually a form of not letting children go, or not allowing them to differentiate from parents.

Some Common Adolescent Pathologies

Depression

One of the more pathological problems that affect adolescents is adolescent depression. When one is clarifying depression as a psychiatrist, one has a classification that includes depression as an illness. This is known as primary depressive illness and tends to run in families. There are many other depressive illnesses one can have, such as the one that can be felt when one has the 'flu, or the one that develops in the early stage of cancer of the pancreas, or goes with glandular fever or alcoholism, and so on. It is very rare for adolescents to contract these kinds of depressions. Mostly, when one sees an adolescent with a primary depressive illness, it is a child who comes from a family with a clear history of biological depressive illness.

The depressions one usually sees in adolescence are those where the adolescent experiences depression as a normal feeling when other feelings are blocked. In other words, as an organism they are *stopped* from behaving in a certain way. This occurs in two particular situations: where one has lost something or somebody, or where one is caught in an aggressive hierarchy. If you are one of the corporals and you cannot cope with an impossible lieutenant, and are unable to express your anger, the feeling becomes depression. This is an internal biological signalling to stop and conserve oneself. Your appearance also signals to others that there is something wrong.

Depression in these cases is a normal affect. Most adolescent depressions occur in such a way. This is partly because they are often powerless in family situations, have made mistakes, and lost parts of their life that they are unable to find again. They are also caught in powerless positions at school.

Another is where the child is in continual conflict with someone in authority. Some of the worst depressions occur when another child in the family is delegated as a parents' lieutenant; for example, in a single parent family where the parent asks the elder to control the younger. The older child with the delegation of parental authority is usually not compassionate, usually has their own sibling rivalry to deal with, and is often quite merciless. Some of the worst adolescent depressions are where the adolescent has been dealt with very severely by a sibling and seemingly with the parents' consent.

The situation where the adolescent feels that the parents are strongly united against him/her is another which can cause depression. This may include the case where one parent is completely despotic and the other parent is always supporting him/her. Sometimes one child in the family has the role of the "goodie", and another the "baddie"; the latter feels very much on their own, overpowered, and that the rest of the family is united against him/her and his/her needs are not recognised or met.

There are issues of personality development that are indications of depression. For example, the person who is developing an ideal self which is so unrealistic they can never reach it. This involves continual loss and fight within the personality. Similarly, the passive dependent person who always needs someone

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in the vicinity to mother them. These persons have a continual sense of loss and deprivation.

Adolescents utilise many defense mechanisms: sublimation, aggression, hostility, acting-out in various ways - sometimes including anti-social behaviour - graffiti, marihuana and other drug usage, in coping with their problems. Depression is usually one of their last resorts. A persistently depressed adolescent is a matter for concern. In older age groups, such as middle age, depression can frequently be an immediate reaction. It is much more socially acceptable in middle age because adolescent excesses are not permitted.

Some depressed adolescents may be those suffering from guilt, as discussed above, with a scrupulous personality and very low self-esteem, and who are continually introspective, and self-punishing. This type of depression is more common in older age groups. For this to happen at 12½ years augers badly. On the other hand, if one does a great deal of work with such a child and their family, there is still a lot of flexibility and a lot of personality development to take place.

Acting Out

Some of the other disorders include acting out. Nowadays, "acting out" is very important in understanding a lot of pathological reactions that happen outside the home. Acting out is really another of the defence mechanisms, as illustrated by Anna Freud, which included rationalisation, sublimation, suppression, introspection and projection and similar intra-psychic defence mechanisms whereby people avoid conflict and avoid anxiety. Acting out is a special defence mechanism.

Acting out means that the person *does* something rather than experiencing painful feelings. The psychoanalytic theory is that when they are faced with an unbearable feeling, instead of experiencing the feeling, they defend by acting in some way. It is essentially "flight". When they do act out, the actions are often related to the painful issue that they are avoiding. For example, they may perform "masterful" behaviour as an alternative to feeling small or humiliated. Or they might do something dangerous to cope with feelings of fear. That is they might do the very thing of which they are afraid; thus they may take major risks on their motorbike or something similar as a means of controlling their fear of death or mutilation.

The adolescent who acts out is not developing their internal resources. The alternative to acting out involves coping with bad feelings, bearing them and continuing to think. It involves being frustrated and yet continuing to function and to look at long-term goals while experiencing the difficult feelings; it involves being able to control one's aggression and re-channel it.

In assessing acting out, one sees symbolically the associated conflicts. I use the example of the stressed man who stole a whistle and managed to be caught. A similar form of theft is probably the most common form of motivation associated with adolescent theft. They are really broadcasting a message which is a cry for help on behalf of themselves or the family, but not often as directly symbolic as the stealing of a whistle.

Another acting out behaviour can be the stealing of cars which give adolescents a sense of mastery because, at another level, they see themselves as deprived of this by an adult's law. Much depends on relationships with adults, and if the relationships are good, their hostility will not usually express itself in something as major as car theft.

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Another key factor is the group dynamic of the boys with whom the adolescent mixes. It might be an aggressive dynamic against adults or the police; sometimes it can be care-eliciting, because if caught, the boy is surrounded by involved male figures - policemen, a district officer, a lawyer, a magistrate, even, perhaps, a psychiatrist, who may all give support, entering a life that was, possibly, bereft of supportive attention. This may satisfy an adolescent's developmental needs at this stage. Sometimes there may be a boy who needs the approval of others and is led into a car stealing group as the only way he knows of being accepted. If adolescents are hostile enough, they may take the car out into the bush and burn it, not just ride around in it, park it, and walk away.

But in most instances the disturbed behaviours of adolescents are a response to a crisis or a stressful stage of development. Adolescents tend to be very flexible and innovative in their development.

It is important not to see a transitory stage as a permanent aspect of the adolescent personality even if it appears as major turmoil. They will usually develop beyond it.

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